1-1-2008

Pakistani immigrants and their challenges in accessing culturally diverse physicians in the Toronto CMA

Wafa Raza
Ryerson University

PAKISTANI IMMIGRANTS AND THEIR CHALLENGES IN ACCESSING CULTURALLY DIVERSE PHYSICIANS IN THE TORONTO CMA

Wafa Raza, BA (Honours), University of Toronto, 2001

A Major Research Paper
presented to Ryerson University

In partial fulfillment of the requirements for the degree in

Master of Arts
in the Program of
Immigration and Settlement Studies

Toronto, Ontario, Canada, 2007

Author's Declaration

I hereby declare that I am the sole author of this major research paper.

I authorize Ryerson University to lend this paper to other institutions or individuals for the purpose of scholarly research.

I further authorize Ryerson University to reproduce this paper by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

PAKISTANI IMMIGRANTS AND THEIR CHALLENGES IN ACCESSING CULTURALLY DIVERSE PHYSICIANS IN THE TORONTO CMA

Wafa Raza, 2007

Master of Arts
Immigration and Settlement Studies
Ryerson University

ABSTRACT

This research concerns the health experience of both new and long-term Pakistani immigrants living in the Toronto CMA and focuses on their experiences of utilizing culturally diverse family physicians. It considers their spatial context of healthcare access and the leading barriers to access they face. Attention is given to the gendered experiences of Pakistani women and the influence of culture and socio-economic factors as determinants of health. The study implies Pakistani newcomers experience significant challenges to adequate healthcare access as opposed to mature Pakistani immigrants, in terms of their English communication skills, access to transportation, lack of social/familial ties and awareness.

Key Words: Acessibility; Healthcare; Pakistani immigrants; Toronto CMA

Acknowledgements

I would like to take this opportunity to sincerely thank you Dr. Myer Siemiatycki for being a great source of support and understanding through out my period of graduate studies. Thank you, Myer.

Dr. Lu Wang, my supervisor, I am grateful that I got a chance to learn from you. I truly value this research experience. Thank you for all of your guidance. Thank you, Dr. Francis Hare for being my second reader and offering your comments.

This research project could not be possible without the help of my Mom and Dad, my sister, Chandi and my brother-in-law, Francis. May God bless you for your understanding in my time of need.

Last but never the least, I will thank you the complete inspiration in my life, my husband, Raza. I love you. I love our children and the future we have together, Insh'Allah. Imaan this is all for you, my sweet sweet princess.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

Chapter 1: Introduction

This research aims to explore Pakistani immigrant healthcare seeking behaviour and the leading issues preventing new and mature Pakistani immigrants from accessing adequate healthcare services in the Toronto Census Metropolitan Area (CMA). In Canada the role of geography in healthcare access is crucial in the face of neo-liberal policies impacting the healthcare system. A widely accepted point of view holds that medical care is easier to access if it is geographically nearby (Wang, 2007). Within a multi-ethnic context, the demand of various ethnic groups differs across cultures according to different health beliefs and traditions including the provision of healthcare in terms of a physician's language of practice (Wang, 2007). Furthermore, physicians situated in a common place but with differing ethnicity may attract immigrant patients differently. Thus the interplay of ethnicity and culture along with the proximity to healthcare are key factors in determining access by immigrants to physicians.

With reference to Pakistani immigrants, this paper will first explore their spatial locations in the Toronto CMA. Next, analysis on the ways in which they are impacted by the shortage of family physicians in Ontario will be addressed. Third, this study will discuss the gendered dynamic: what are the unique challenges in obtaining healthcare services for Pakistani immigrant women? Lastly, analysis towards the socio-economic factors of health and how they differ for a new Pakistani immigrant and a mature Pakistani immigrant will also be explored.

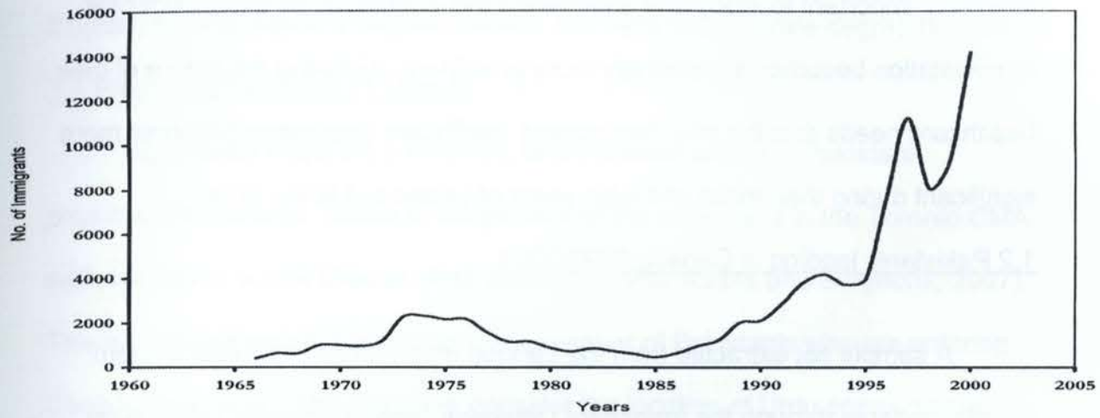
This research gives focused attention to immigrants from Pakistan, who constitute past and current top sources of immigration to Canada. My interest in healthcare issues and how they impact Pakistanis is a product of different influences. First, being of Pakistani origin, having lived and worked in Pakistan, I am keen to understand the healthcare issues in my community that impede or prevent proper healthcare access. Secondly, no previous studies of ethnic groups in the Toronto CMA have been conducted in the healthcare context; with the exception of the Chinese ethnic group (Wang, 2007). Lastly, this is a current perspective on the role of ethnicity and culture and how they interact to influence the use of healthcare. Nonetheless the growing immigrant population in Toronto, calls for the need and importance of adequate healthcare access for all.

1.1 Historical Background of Pakistanis in Canada

The Pakistanis, a previously overlooked ethnic group in Toronto, account for the fourth largest immigrant population landing in Canada since 1999. An historical analysis reveals that Pakistani immigrants started to immigrate to Canada in small groups in 1957, dispersing themselves all over Canada (Awan, 1989). As the Canadian immigration policy gave preference to individuals with advanced education and professional skills, those who came at this time had exceptional credentials and were mostly young men pursuing professional degrees. The earliest statistics on Pakistani immigrants is found in 1966 as displayed in Figure 1. This graph shows that in the 1970s the first wave of immigration occurred peaking in 1974 when 2, 315 Pakistanis entered Canada. The 1980s plummeted as a result of new immigration stipulations reducing

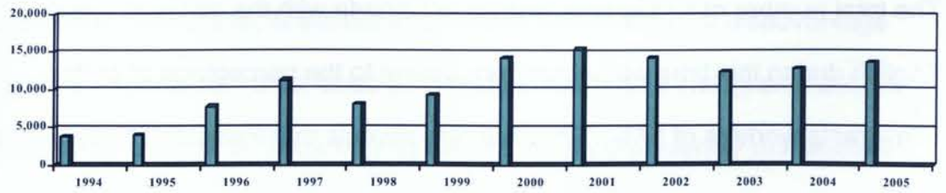
opportunities for professionals and rising tuition fees for foreign students (Magocsi, 1999).

FIGURE 1: TOTAL NUMBER OF PAKISTANI IMMIGRANT ENTERING CANADA FROM 1966 TO 2000
(Source: Citizenship and Immigration Canada, 1966-2000)



Since 1996, as depicted in Figure 2, Pakistani immigration has become more significant for Canada with Pakistan being among the top ten source countries of immigration. According to Citizenship and Immigration Canada, officially 118, 844 Pakistani immigrants over the span of a decade entered Canada as of 2005. Thus, in the latter part of this period from 2000 and onwards, the average percentage of Pakistani distribution was 5.8% of immigrants in Canada (Citizenship and Immigration Canada, 2005). It is ironic

FIGURE 2: Pakistani Immigration to Canada 1994-2005
(Source: Citizenship and Immigration Canada, 1994-2005)



while the "war on terror" has put Pakistanis at the forefront of public scrutiny, in 2001 (when Pakistani immigration peaked at 15, 354) and the following years did not impede Pakistani immigration into Canada. Since 2001, Canada has had the most significant inflow of Pakistani immigrants landing in its history. It is inevitably important to study and understand this population as their residential manifestation becomes increasingly more prominent, exploring the nature of their healthcare needs and the way they access healthcare physicians becomes more significant during their initial and later years of settlement in the GTA.

1.2 Pakistanis landing in Canada 1996-2001

A sample set extracted from the Landed Immigration Database System (LIDS) available through the Immigrant Database (IMBD) indicates that a large majority of Pakistanis immigrated to Canada from 1996 to 2001. The Pakistanis entering Canada during this time were categorized under the skilled worker immigrant class (58%), followed by the assisted relative class (17%) and the family class (15%) as Table 1 portrays.

TABLE 1: **Immigration Class of Pakistanis from 1996-2001**

Immigration Class	Years Of Landing						
	1996	1997	1998	1999	2000	2001	Total
Family Class	600	843	1004	1743	1767	2338	829
Assisted Relative Class	1273	1767	1111	970	2055	2002	917
Entrepreneur Class	433	530	259	280	299	654	245
Other Independent Class	4017	6515	3946	3700	7020	6726	3192

The total number of immigrants landing in Canada with the ability to speak English during this time was almost equivalent to the percentage of skilled immigrants workers of 57%. The data also reveals that Pakistani immigrants are

a fairly well educated group; there is a positive correlation with their educational background and English speaking ability. That is, as the education level of the Pakistanis increased, their ability to speak English increased as well. For example, 79% of immigrants with a Bachelor's degree were able to speak English, 88% of Master's degree holders, and 94% of Doctorate degree holders.

1.3 Pakistani Physicians in Toronto

Apparently there are a relatively large number of ethnic Pakistani physicians in Toronto. Close to 9.3 percent of the physicians in the Toronto CMA self-reported to speak Urdu or Hindi (College of Physicians and Surgeons, 2007). This is a sizable number considering the number of Pakistanis who are entering Canada each year. This study will consider the location of Urdu-speaking and Hindi-speaking physicians as these two languages are mutually understandable and Pakistani immigrants are generally believed to be bilingual, that is by speaking Urdu they are considered well versed in the Hindi language as well. Thus, the location of these physicians will help assess if these immigrants are at a stark disadvantage given their relative location to an Urdu or Hindi speaking physician and the explore the nature of these disadvantages. As healthcare research highlights a significant dynamic: the cultural differences between healthcare providers and users can create barriers due to their ineffective nature of communication and treatment (Zhang & Verhoef, 2002; Wang, 2007; Leduc & Proulx, 2004). Given this, is the communication barrier the only disadvantage immigrants' experience? If so, does this change over time if immigrants acquire the English language? Acknowledging the unique cultural identity of Pakistani

immigrants, this research will also explore how the changes in healthcare accessibility may change over the length of residence in Canada. It is predicted newer Pakistani immigrants experience many more problems in healthcare accessibility overall when compared to mature Pakistani immigrants who do have become accultured to Canadian society and the healthcare system.

Chapter 2: Literature Review

The literature in the field of immigrant groups' accessibility to healthcare is a fairly recent phenomenon having developed more than twenty years ago but gaining more attention and coverage following 2000 as the selected resources reveal. A stream of writing, in the context of healthcare utilization has discussed the geographic access to health services; even more precisely the accessibility to physicians (Laditka, 2004; Luo & Wang, 2003). The authors integrate both spatial factors (the uneven distribution of healthcare providers and consumers) along with non-spatial factors (differences in socio-economic and demographic characteristics) to distinguish the areas comprising poor access to primary healthcare using GIS applications (Luo & Wang, 2003). The research conducted intended to measure spatial accessibility based on travel time, and thus gave significant insight into an otherwise understudied aspect of healthcare accessibility in Canada. This project will examine the residential distributions of Pakistani immigrant groups and plot out the spatial accessibility of Pakistani immigrant groups in the GTA to healthcare practitioners with use of GIS methods. Past literature has a tendency to treat physicians as a homogeneous group without realizing the ethnic diversity of physicians that may exist in places like Toronto. This study will also examine the ethnic diversity of physicians with a Pakistani focus and explore how their language of practice may impact the preference of Pakistani immigrants in accessing healthcare.

In the broad context of health geography, Rosenberg considers the nature of access and how healthcare programs are administered (Anderson &

Rosenberg, 1990). He makes the assessment that research in the field of health geography pertaining to the racialized aspect of health and how it impacts the quality of healthcare has not been properly studied. Now that a decade has passed since his assessment, still limited attention has been given to the role of ethnicity and racialized aspect of immigrant health. On a more positive note, what has been explored is the health of immigrant women (Dyck, 2004; Meadows et al, 2001; Hussain & Cochrane, 2005; Hilton et al, 2001; Williams & Garvin, 2004). In Vancouver, it was found that immigrant women from India have a high preference for traditional home remedies to western medications because of their lack of side effects (Dyck, 2004; Hilton et al, 2001). The immigrant women depended greatly upon their social networks in seeking information about and access to healthcare (Dyck, 2004). Although, the dialogue of these punjabi South Asian immigrant women are extremely rich and informative, their experiences in the management of their health and illness are particular to their unique ethnic group. Hence, their method of utilizing healthcare to maintain their health needs cannot be generalized towards all groups of South Asian women. . A variety of gendered experiences representative of different ethnic groups give a clear picture on the specific nature of access to healthcare and allow for comparisons to be made based on gender. In light of this study however, we will only consider the gendered experience of Pakistani women and how they experience accessibility to healthcare and the nature of the challenges they endure.

Literature highlights Morton Beiser (1988; 1993; 1997; 2002; 2004) as the pioneer in the research of healthcare and mental health issues of immigrant populations in Canada. In the context of immigrant mental health experiences in Canada, the studies pertaining to this field yield substantial collections of literature. Beiser (Beiser, 1988; Beiser et al, 2004; Beiser et al, 2002; Beiser et al, 1993; Beiser & Wickerman, 2004; Beiser & Hyman, 1997) has fiercely orchestrated several studies in the mental health experiences of Southeast Asian refugees in Vancouver. His earlier studies of the influence of time, ethnicity and depression related to Southeast Asian refugees conducted in the late 1980s are a pivotal reference point in the field of healthcare research. Even today, Beiser's research is the most current knowledge of the barriers to mental health services experienced by a minority group in Canada. Although it is pointed out that Somali immigrants experienced language barriers in finding and accessing mental health services (Simich et al, 2005), the precise nature of the challenges in accessibility (in terms of ethnicity, language, spatiality) for this particular group are not outlined. In respect to other groups, like the Pakistanis, it leaves much room for further research in exploring the nature of challenges in accessing healthcare services.

Another focus central to this paper is the socio-cultural context specific to ethnicity and healthcare utilization (Leduc & Proulx, 2004). This issue highlights the cultural differences between healthcare providers and users and how they can create barriers due to the ineffective nature of communication and treatment. This may result by the misinterpretation of patients' symptoms and difficulty

arising in bridging Western medical science and its knowledge to individuals of traditional ethnic communities (Zhang & Verhoef, 2002). An important determinant of health care consumption is found within the social networks or "ethno cultural affiliations" that predispose a specific utilization behaviour (Leduc & Proulx, 2004; Dyck, 2004; Hilton et al, 2001; Williams & Garvin, 2004)). However, even common barriers of accessibility of various ethnic groups can give rise to equivalent utilization behaviours. For example, language barriers may motivate the utilization of a professional of the same ethnic group. Conversely, differences attributed to individual characteristics with an ethnic group may bring differing outcomes (Leduc & Proulx, 2004). For immigrants who are health professionals in their country of origin, they are likely to have different perceptions of health services compared to other families of the same ethnic group. In addition to these findings, the length of stay was a sharp predictor of changes in utilization choices and strategies that are produced once the contact with the host society develops and the use of health services increases (Leduc & Proulx, 2004). Even though all of these issues will be studied and applied to how they impact Pakistani immigrants, they notably do not explore the context of spatial / geographical barriers immigrant groups may initially face in attempts to locate health care providers specific to their ethnicity and/or health care needs. Indeed, this research will compare the experiences of new Pakistani immigrants to mature Pakistani immigrants to understand how their access to healthcare changes over time of residence in Canada.

It was surprising to realize that geographical studies on the access to healthcare while focusing on the spatial outcome of the uneven distribution of care providers and consumers, pays limited attention to immigrant users and the role of ethnicity in accessing health services. From this perspective, this research aims to fulfill the gap between geographic literature on access to healthcare and how it relates to the socio-cultural aspect to health.

A significant contribution to this research is the study conducted by Lu Wang (2007). In her study, she explores how Chinese immigrants in the Toronto CMA choose between ethnic Chinese family physicians and other family physicians. Wang concluded that there is a degree of spatial mismatch between immigrant healthcare demand and the supply of culturally diverse physicians Chinese immigrants seeking a Chinese speaking family physician faced more competition if they lived in the Scarborough or downtown Toronto areas. The importance of having access to physicians who speak Chinese and have some cultural understanding of their health traditions and beliefs plays an integral role in the quality of life for immigrants (Wang, 2007). The nature of my study will extend from Wang's substantial work on the Chinese community and will be central to the research on Pakistani immigrants. It will determine if the concept of a "spatial mismatch" exists between the Pakistani immigrant healthcare demand and the supply of Urdu-speaking physicians and what kind of difficulties (or competition) exist in obtaining Urdu-speaking physicians in certain areas in the Toronto CMA over others. Spatial mismatch refers to the geographical disparities in service provision and uptake in a given area (Newbold et al, 2007).

Essentially, Wang's study is the first in the field of ethnic minority populations and the problems they encounter in accessing ethnic healthcare practitioners. It is also the first study to acknowledge that the physicians of Ontario are a culturally diverse group as diverse as the population. I intend to contribute to the scant literature in this rather important field and build upon what Wang has already accomplished.

Chapter 3: Research Methodology

The research methodology for this study will consist of a mixed approach that includes a combination of primary data and secondary data. Primary data includes a qualitative method (questionnaires with practitioners and focus groups with new and mature immigrants) and secondary data is based on quantitative data in its collection of aggregate data from Statistics Canada, and Citizenship and Immigration Canada, the use of GIS and data obtained from the College of Physicians and Surgeons of Ontario (CPSO). For the type of research to be conducted, I believe I have a great advantage of sharing the same ethnic background of the focus group participants and questionnaire participants that will allow me to understand their issues and concerns in greater depth. I hope it will facilitate the development of a positive rapport and thus, produce a rich, detailed discussion based on mutual respect and understanding.

3.1 Primary Data

The first component of primary data collection was in the form of focus groups. Three focus groups were arranged consisting of new Pakistani immigrants who have recently arrived in Canada over the last 2 years and mature Pakistani immigrants who have been in Canada for at least 10 years. Although the focus groups aimed to be representative of the GTA, focus groups were specifically held in East York, North York and Markham for the purpose that I received the greatest response from Pakistani individuals in these respective areas interested to participate in the study (see Figure 3). Two focus groups were designed for new Pakistani immigrants mainly because I received

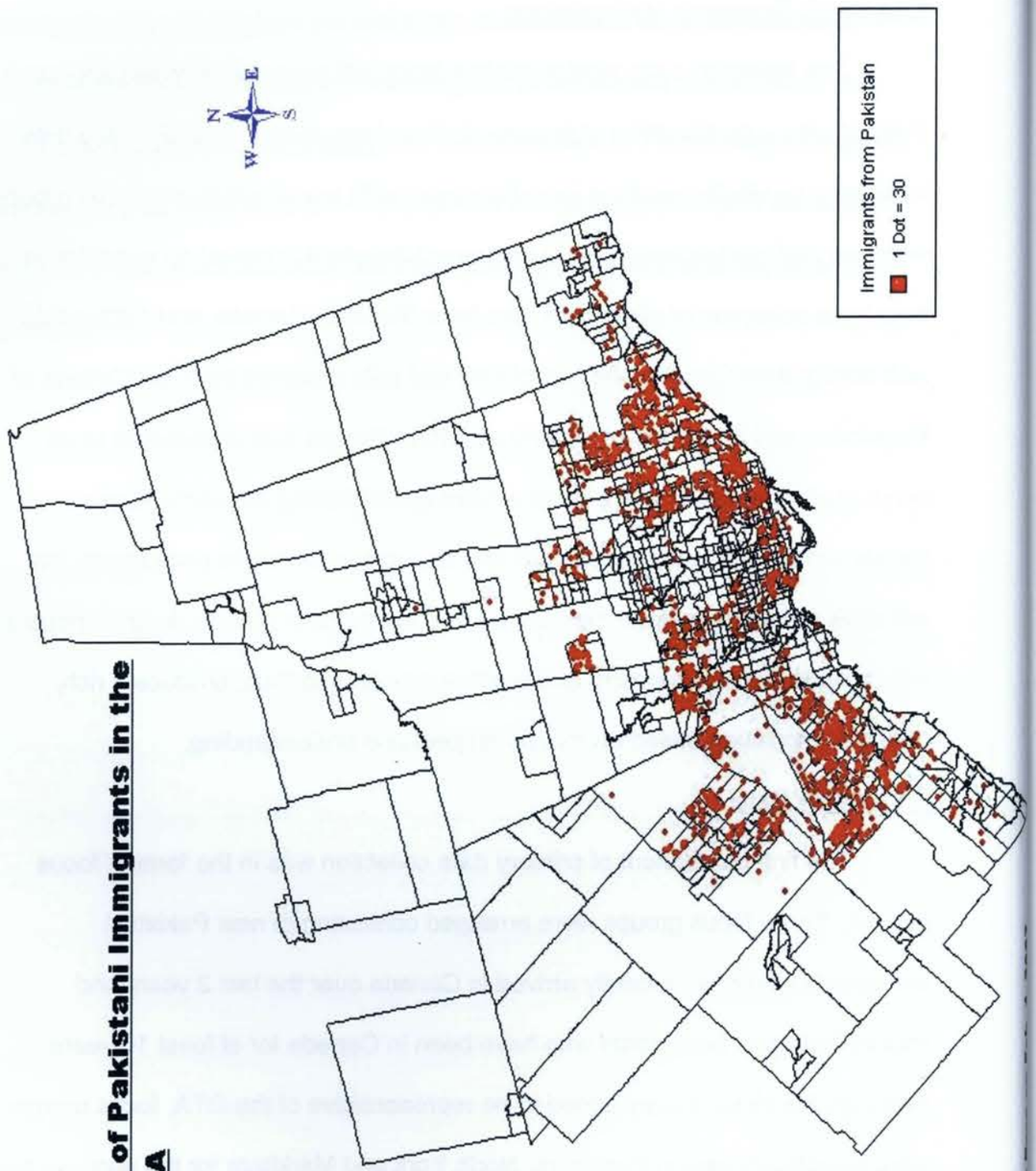


FIGURE 3
Distribution of Pakistani Immigrants in the Toronto CMA

a significant response from new immigrants in the areas of East York and North York. A close look at Figure 3 indicates that a large concentration of Pakistani immigrants live in East York and likely in North York, a cluster of Pakistanis live in the north-west and east side of the municipality. The majority of participants in the North York area who showed interest for the second focus group were female. They felt extremely uncomfortable having a focus group with male participants unknown to them and felt it was religiously inappropriate as the majority of them wore traditional Islamic hijab or a head cover. Thus, with the help of my supervisor we decided it would be interesting to explore the unique experiences of these women and agreed to exclude males from this particular focus group. The first group comprised a mixture of four females and three males from the Census Sub Division from East York, specifically from the Thorncliffe Parkway Area; the second focus group targeted seven females from North York in the Weston area. The third focus group was representative of three female and three male mature Pakistani immigrants from the Mississauga, Markham, and Scarborough areas which all have a large population of Pakistanis especially in Mississauga and Scarborough (see Figure 3). The idea was to have each focus group representative of the Pakistani population in the GTA. However, as partly explained earlier due to the stringent time constraint, I was limited by the number of people willing to partake in this study. The first two focus groups conducted with the newcomer Pakistani immigrants were very emotional experiences. These sessions lasted on average 66 minutes and all of the immigrants had a disturbing story to share regarding their healthcare

experience in their respective locations. The first focus group was completed in English at the Thorncliffe Neighborhood Office and facilitated by a settlement worker named Nawal Ateeq. The second focus group was organized by Dr. Nasir Ahmed Sheikh, the President of the Ahmadiyya Movement in South Weston and was conducted in Urdu at his home in North York. The first two groups were compensated in the form of a cash honorarium.

The final focus group consisting mature Pakistani immigrants was conducted in English and organized by myself; I personally invited each individual to participate in the study. One participant suggested having the focus group during dinner at a restaurant and everyone mutually agreed on this. I utilized each participants' honorarium in paying for the meal. Hence, the last focus group was held at the Mandarin Restaurant located in Markham and it lasted for 52 minutes. Table 2 is a chart comprised of the socio-economic factors of the participants who took part in the study.

TABLE 2: PROFILE OF FOCUS GROUP' PARTICIPANTS

Focus Group	Residence	Years of Stay	Marital Status	Age	Education	Home	Employment
1) New Pakistani	East York	7 months-	Married (7)	25-34 yrs (4)	Gr.12(2)	Rent (7)	Unemployed (6)
Immigrants		1yr		35-50 yrs (2)	B.A.(2)		E.I. Benefits(1)
Male Participants:3				50-64 yrs (1)	B.Eng (1)		
Female Participants:4					M.B.A. (2)		
2) New Pakistani	North York	6 months-	Married (4)	15-25 yrs (4)	Gr. 9 (1)	Own(1)	Part-time (3)
Immigrants		1.5 yrs	Single (3)	25-34 yrs (2)	Gr.11(1)	Rent (6)	Unemployed (4)
				35-50 yrs (1)	Gr.12 (1)		
Female Participants: 7					F.A. (4)		
3) Mature Pakistani		31-38 yrs	Married (5)	50-64 yrs (6)	M.Sc (1)	Own (5)	
Immigrants			Divorced (1)		M.A. (1)	Rent (1)	Retired (4)
	Markham (3)				B.A. (2)		Director (1)
Male participants: 3	Scarborough (2)				B.V.Sc (1)		Machinist (1)
Female participants: 3	Mississauga (1)				Grade 12 (1)		

I chose to conduct focus groups as opposed to data collection methods for a variety of reasons. Focus groups are an effective way to illicit feelings, reactions, and experiences of specific scenarios. Ideally they are useful in two main regards. They provide a way to gain insight into "the spectrum of views individuals hold regarding a particular issue and the nature of that issue" (Flowerdew & Martin, 2005, 129). As a core research method, focus groups will give greater insight into participants' understandings and views of accessibility to healthcare services and how these views relate to one another. The effect of having two focus groups with differing length of residence in Canada will highlight how the views of Pakistani newcomers differ from mature Pakistani immigrants. Therefore, the advantage of this method is the revealing context of experience disclosed by the participants. The real strength of focus groups is not simply exploring what people have to say but in providing insights into the sources of complex behaviours and motivations (Morgan, 1996, 139). It is relevant to healthcare research as the purpose of the study is to look at immigrant's firsthand experiences with ethnic physicians and explore the cultural aspect of their healthcare experience. Considering the time frame and budgetary constraints of this research, focus groups are a good time saving strategy and the most effective way to collect such information. Morgan and Krueger (1993) insist when participants both query each other and explain themselves to one another is what makes the discussion in focus groups more than the sum of individual interviews. It is emphasized that such interaction offers valuable data on the extent of consensus and diversity among the participants. Thus, this

ability to observe the nature of interviewee's agreement and disagreement is a unique strength of the focus group (Morgan & Krueger, 1993).

The questions for discussion of the three focus groups (see Appendix A) consisted of questions pertaining to views rather than their personal history. As well, it was well acknowledged that the coordination of a mutual time and place among three groups of 6-8 individuals would prove difficult. A challenge and potential weakness in orchestrating a focus group is it does not allow each individual's perspective to come through equally as some participants will inevitably have more to say than others on the topic (Morgan, 1996). In addition to the likelihood of uneven coverage between individuals, the group dynamic may lead to an under-reporting of those views and opinions individuals perceive to be controversial or significantly different from those of the others present (Flowerdew & Martin, 2005). As the moderator of the focus groups, I did experience this at a few instances in the first two focus groups with the newcomer Pakistani immigrants. There were some individuals who had more to say than others and when I could sense others were not getting an opportunity to contribute, I would refer to them by name and ask them the question directly so as to include them in the conversation and welcome the chance for them to contribute. I found this way to be most effective. In fact this procedure was necessary as being the moderator, I was well aware that my behaviour had consequences for the nature of the group interviews. Thus, it was up to me to be strategic in giving everyone an opportunity to speak and voice his or her point of view.

As for the experience with the mature Pakistani immigrants, they were extremely respectful of one another, everyone gave each other a chance to speak and contribute probably because each participant had many positive experiences to share about the healthcare system.

The second component of primary data was short questionnaires with South Asian physicians. It is cited that the value of surveys can be more effective for determining the prevalence of any given attitude or experience (Ward et al, 1992). Apart from this, since the surveys were administered online, it was considered a significant budget and time saving strategy. It is also convenient and fast for the physicians to deliver the completed survey as the responses to online surveys can be transmitted to the researcher immediately via email or posted to an HTML document or database file (Fricker & Schonlau, 2002), (Wright, 2005). Furthermore, a portion of the survey asked open-ended questions giving physicians the opportunity to share their insight. This was an integral aspect of the questionnaire and an effective way to learn and understand the types of issues physicians encounter among their ethnic patients (Fricker & Schonlau, 2002), (Flowerdew & Martin, 2005). One of the most widely recognized shortcomings of online questionnaires is the response rate (when no other survey modes are given) have rated as moderate to poor. The reasons for this are unclear; it could be that individuals do not respond well to electronic solicitation or response (Wright, 2005).

3.2 Recruitment Strategy

In this whole process, the recruitment strategy was vital as it determined how I would go about locating the participants I required in order to conduct the short physician survey and the focus groups. The snowball technique was utilized to survey ethnic physicians. This technique involves using one contact to help the recruitment of another contact, who in turn can put the researcher in touch with someone else. This I thought would be an effective tool to locate healthcare practitioners in different areas of the GTA. I contacted South Asian physicians known to me in the GTA. Considering my absence from the GTA during the summer, I contacted 5 physicians of South Asian origin far in advance knowing they have busy schedules and I discussed my research. When they confirmed their willingness to participate in my study, I received their electronic mail address. The survey asked specific questions pertaining to physicians' experiences regarding the interplay of ethnicity and healthcare among their Pakistani patients (see Appendix B). I did consider the physician's willingness to participate was dependent on their availability and thus, there was no guarantee a physician was obliged to participate. Indeed, I send the questionnaire as an attachment to potential respondents via e-mail. In the end, I did not receive any completed surveys from the physicians who said they were interested. Thus, my backup strategy involved contacting a younger group of South Asian physicians who are also known to me from my undergraduate studies at the University of Toronto. Being referred to other South Asian physicians through two sources, I send out a total of 8 surveys and received 2 completed surveys. I did not think

obtaining short surveys would be this difficult to do. The main comments from the physicians who did complete the survey indicated that other physicians known to them would be far too occupied to complete the survey but they forwarded the survey electronically anyway. I learned later, it would have been more beneficial to conduct face-to face interviews with the physicians.

For the focus group of mature immigrants, I knew all the individuals personally. I made phone calls to these long established family friends and told them about my research project and invited them to participate in the focus group with the meal incentive as discussed earlier. On the other hand, the recruitment for new immigrants proved far more challenging. Some key informants (also known to me) in the community referred me to individuals working with community organizations and settlement agencies in the GTA. Via electronic email, the representatives from the community organizations and settlement agencies contacted Pakistani newcomers and mature immigrants (previously described as the snowball technique) known to them who would be willing to participate in this study highlighting that a honorarium would be provided. Although initially I did receive a good reply, I followed up with representatives who seemed more serious about helping me in my study. Both of the focus groups concerning new immigrants were confirmed the day before they were held, once the representatives were able to confirm a specific number of Pakistani participants.

3.3 Secondary Data

This component was mainly based on quantitative data. This data is

extremely relevant for the research, as it provides significant contextual material for my primary data. The secondary data includes aggregate data from Statistics Canada of Census 2001 regarding the population (in numbers) of Pakistani immigrants entering Canada since 1966. As well, specific sample data was extracted from the Landed Immigration Database System (LIDS) available through the Immigrant Database (IMDB). This sample of the Pakistani population derived valuable information pertaining to the number of immigrants, immigrant class, language ability, and educational status of immigrants landing in Canada from 1996-2001. These variables have been tremendously valuable in understanding the sample population who landed in Toronto recently and in the past. Thirdly, by extracting data from the most previous census period 2001, Geographic Information Systems (GIS) was utilized to make maps using the MapInfo software. The data was utilized to outline the settlement patterns of Pakistanis, their relative concentration in the GTA, the distribution of Pakistanis, Indians and Sri Lankans, the distribution of Urdu-speaking Physicians in the GTA, and the distribution of Hindi-speaking physicians in the GTA. These maps act as a great visual aid and will be an asset to my research. Next, the College of Physicians and Surgeons of Ontario (OPSO) provides physician data highlighting the location of a physician, their years in practice, their language ability and the type of practice. This will also prove helpful in determining the context of spatial location of the Urdu and Hindi-speaking physicians in the GTA. Lastly, the South Asian Directory provided the addresses of South Asian businesses, services (including health services), and restaurants/grocers across

the GTA whereas the Yellow Pages were used to find the addresses of mosques and Islamic schools.

Chapter 4: Analysis

This portion of the study will first examine the spatial residential choices of Pakistanis in the GTA and help explain how the interplay of culture and religion influence their settlement. In this way, the role of accessing healthcare and its importance in residential choice will become evident. Second, the nature of problems experienced in accessing healthcare as discussed in the focus groups will be looked at, as will the root cause of the problems in terms of the physician shortage in Ontario. Next, the focus will turn to new Pakistani migrant women and the nature of difficulties they endure in the availability of healthcare services and other problems specific to this gendered group. Fourthly, the cultural difference in medicine, the role of culture and how it influences ethnic physicians in their daily practice will be touched on. Lastly, the socio-economic factors and mental health issues as determinants of health will be explored and compared in context of the profile data of the participants with their respective municipal profile data.

4.1 Spatial Location of Pakistanis in the GTA

As of 2001, the geographic distribution of Pakistani immigrants in the GTA shows they are relatively scattered having some concentrations across the GTA. As discovered in Figure 3, Pakistani immigrants show a particularly increased density in East York, Scarborough and Mississauga. It is suspected that the high number of mosques and Islamic organizations in Scarborough and Mississauga partially explain the spatial residential choices for many recent immigrants who

value their religious affiliations and likely, their accessibility to worship. Scarborough may have affordable housing schemes while Mississauga has become home to a significant number of elder Pakistani immigrants acquiring upward mobility and the desire for spacious and improved standard of living especially now that it is presumably affordable for the established immigrants. The East York region has a well-known reception area for newcomers known as Thorncliffe Parkway and it represents the largest concentration (10-20%) of Pakistanis (Statistics Canada, Census 2001). This area is comprised of several low-end, low-cost, and overcrowded high rises. Over the years, it is evident that many Pakistani newcomers continue to initially settle here for the moral support and comfort of the community, allowing the immigrants to be 'close to home' so to speak (Balakrishnan & Gyimah, 2003).

Even when the density of Pakistanis in Brampton, and Etobicoke is significant, it is not comparable to the magnitude of population growth in Scarborough and Mississauga. Mississauga seems to have the largest dispersed population of Pakistani immigrants with one cluster of 10-20% located at Erin Mills Parkway and Dundas Street East, with five other concentrations of 5-10% and several pockets of up to 5%. As for the Scarborough area, like East York and Mississauga, there is one concentration (10-20%) of Pakistani immigrants and smaller concentrations of the group with two clusters of 5-10% and many smaller clusters of up to 5% (Statistics Canada, Census 2001). This map shows a tendency of the Pakistani population to settle more and more into the inner and mainly, the outer suburbs. The inner city with a minimal population

in Toronto shows a drastic push outward from northern Toronto, central North York and York municipalities with a sprawling population heading mainly southwest (to Mississauga) or northeast (to Scarborough).

4.2 Factors Contributing to Residential Choice:

4.2.1 South Asian Community

The spatial relationship between healthcare opportunities and settlement choice will be explored in terms of the Urdu/Hindi services located in each area. I can only speculate on the factors that may have influenced Pakistani residential choice since no previous references or past studies. Many newcomers most likely do not have access to systemic information on the location of Urdu/Hindi speaking physicians before they make a decision on where they are going to live. However, Mosques are more prominent in space and can probably have more of an impact on settlement choice. Thus, by considering the influence of the South Asian community and the role of their social and religious organizations, the reality of healthcare accessibility becomes clearer.

The map displayed in Figure 4 depicts the relative concentration of immigrants from Pakistan, India and Sri Lanka. It seems as though the Pakistanis are not completely inclined to settle in areas with established South Asian communities. The Sri Lankans are widely concentrated in Scarborough while the Indian population is inclined to settle in the west especially in Brampton. In reference to the maps discussed earlier, the Pakistanis although highly scattered in Scarborough and Mississauga, have a high-density population in East York. Parts of western Etobicoke, southern Markham and the northeast

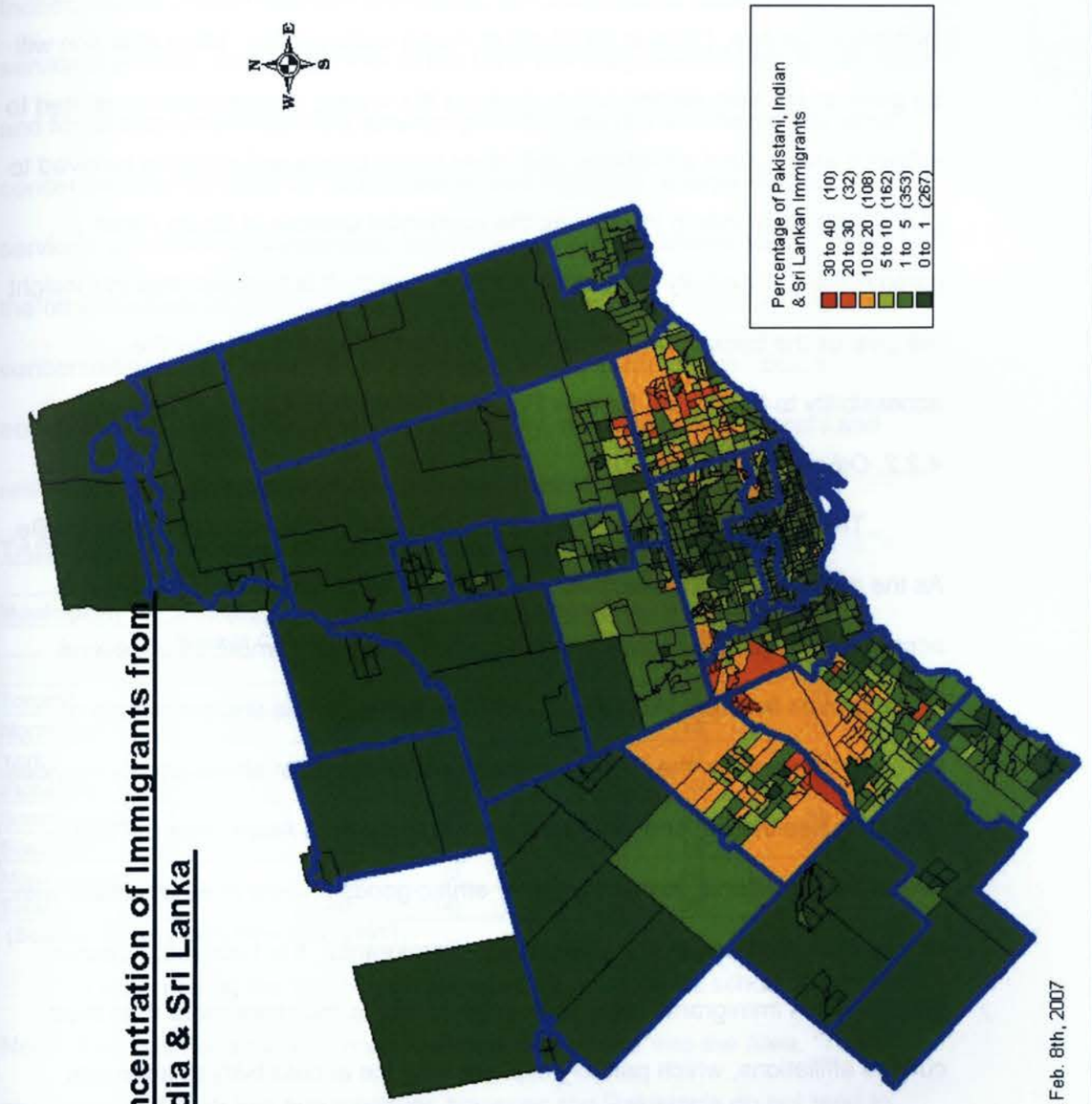


FIGURE 4 **Relative Concentration of Immigrants from Pakistan, India & Sri Lanka**

corner of Mississauga represent several small pockets of dominantly (30-40%) (Statistics Canada, Census 2001) South Asian communities. More attention will be given to the next section which explores the impact of organizations related to religious and cultural affiliations, and other ethnic goods and services believed to play a significant role in influencing the residential choices of South Asian communities, especially the Pakistani ethnic group. It is believed that this insight will give us the background information needed to understand why the accessibility to healthcare for new Pakistani immigrants may be challenging.

4.2.2. Other Organizations

The Pakistanis are an interesting group with a complex community profile. As the majority are Muslims, their requirements for religious organizations or access to mosques is shared with other Muslim groups comprised of several ethnic groups from the Middle East, Africa, southeast Asia and even parts of Europe. Conversely, the Pakistanis identify their needs of ethnic goods, services (including healthcare) and entertainment with the South Asian group. Thus, overtly the Pakistanis, in their quest for ethnic goods and services associate with other Indian, Sri Lankan and Bangladeshi immigrants. It is believed, however, that Pakistani immigrants value their accessibility to mosques more than their cultural affiliations, which partially explains why the accessibility to adequate healthcare is not considered as significant in their early stages of settlement. Since the effort to maintain ones religion is more challenged in a foreign land where Islam is not the dominant religion, Pakistanis do make a concerted effort to maintain and sometimes, improve their religious beliefs and affiliations.

Indeed the Downtown core has the largest concentration of South Asian services, grocers, and restaurants in the GTA that may cater to both South Asian and Muslim communities. The western part of Etobicoke seemingly has large concentrations (20-40%) of South Asians (see Figure 3), a large number of services, grocers and restaurants, four mosques and an Islamic school reflecting the other pockets of Muslim groups that may reside there. However, insufficient concentrations (only up to 5%) of Pakistanis reside in Etobicoke. But, in accordance to its large South Asian community, many services, grocers and restaurants are allocated there as shown in Table 3.

TABLE 3: Allocation of Organizations/Services geared towards Pakistani Immigrants and other ethnic groups

Municipality	Mosque/ Islamic Centre	Islamic School	Organization	Service	Grocer/ Restaurant
Toronto	5	1	5	17	11
North York	5	1	0	14	15
York	2	1	0	0	3
Etobicoke	5	2	1	10	13
Scarborough	11	3	3	21	38
East York	4	1	1	15	27
Mississauga	8	5	0	19	23
Total	40	14	10	96	107

(Source: South Asian Directory, 2001)

It is surprising the number of mosques (5) and Islamic school located in North York has not attracted more Pakistani immigrants into the area. The municipality of York has two mosques however; the Pakistanis do not tend to settle in this area suggesting that a concentration of a large Muslim community exists in York. Similar to its dispersed Pakistani population, the availability of mosques (11) and grocer/restaurants (35) in Scarborough is dispersed throughout the city. Conceivably, this responds to the needs of Pakistani

immigrants residing there as well as the large South Asian (predominantly Sri Lankan population) and the Muslim communities in Scarborough. While there is a large South Asian community in Brampton (see Figure 4), Pakistanis are not widely concentrated there. As such, there is a lack of religious organizations or other services in Brampton usually geared towards the Pakistanis.

The city of Mississauga reveals an overwhelming conglomeration of several mosques, Islamic schools, cultural organizations, services, grocers, and restaurants. There seems to be somewhat of a balance between the number of services and grocers dispersed across Mississauga. However, the four mosques located off of Mavis Road are situated within the centre of Mississauga. Even along the western outskirts of Mississauga where new communities have developed, the mosque is the first built establishment to symbolize new Muslim communities. An important distinction of Mississauga, different from the other municipalities is the large number of Islamic school establishments. The more established and mature Pakistani immigrants settle in Mississauga, thus the construction of Islamic schools speaks to the necessity of religious upbringing and instilling values for future generations as the time in Canada lengthens.

Evidently, given these assertions, the allocation of religious or cultural affiliations and other goods and services in Table 3 do not completely explain the dynamics of why Pakistani immigrants are highly dispersed in Mississauga rather than Scarborough and localized in one area of East York. This portion of the analysis does confirm however that Pakistanis religious and cultural needs are inadvertently being met in different parts of the GTA due to the already

established Muslim groups or South Asian groups residing there. It does also contribute to our understanding of why healthcare accessibility may be of concern to the Pakistani newcomer.

These analyses of different municipalities help us visualize the greater picture in its true sense. Indeed, the development of access to healthcare is related to the residential choices of Pakistani immigrants, however, healthcare issues cannot be understood without considering the other equivalently important and relevant issues newcomer and mature ethnic populations face as they establish and maintain their settlement in Toronto. Now that it is known where the Pakistanis reside and why they choose to reside where they do, the main issues facing Pakistani immigrants in accessing healthcare services during their settlement experience will be explored.

4.3 Healthcare Accessibility

With the utilization of ArcView software, maps were produced giving a visual representation of where the Pakistanis are located in the GTA and where the Urdu-speaking and Hindi-speaking physicians are located (not their geographical residence but their place of practice). Urdu and Hindi are used as the two dominant variables in identifying Pakistani ethnic physicians for the reason that Urdu is the national language of Pakistan, it is widely spoken among Pakistanis and Hindi is extremely similar to the Urdu language. Even though Hindi is widely spoken among Indians, it will be utilized as a form of communication among the Pakistanis in this study. The Punjabi language was not considered in this study, as it is the language of only one province in

Pakistan, the Punjab.

As discovered earlier, in Figure 3, the spatial residential pattern of Pakistani immigrants shows they are unevenly concentrated in the GTA. It was also learned previously that there are large dispersed populations of Pakistanis in Scarborough and Mississauga and a rather dense population in East York. Conversely, the spatial locations of physicians self-reporting to speak Urdu show a different tendency in Figure 5. The Urdu-speaking physicians are concentrated in the Toronto downtown core and dispersed as well across the GTA. In Mississauga, they are found situated more in the centre of the municipality, in Brampton they are huddled near the south border with Mississauga. For Scarborough, they are distributed diagonally from the northwest corner of Scarborough along the bottom southeast of the area. East York, on the other hand, unlike its distribution of Pakistani immigrants, does not seem to have any particular population of Urdu-speaking physicians. As for North York, the distribution of Urdu-speaking physicians is not in vicinity to the Pakistani population. It is important to point out that the physician dots mean there is at least one physician over that location. Moreover, there may be more than one physician in that location. Considering the majority of Urdu-speaking physicians also speak Hindi, the maps (Figure 5 and Figure 6) are similar in many locations. Thus, the analysis of Figure 6 outlining Hindi-speaking physicians shows a very similar trend especially in the Brampton, Mississauga, Etobicoke, North York, East York, Downtown core, Scarborough and Markham areas. Notably, there is a larger density of Hindi-speaking physicians compared to Urdu-speaking

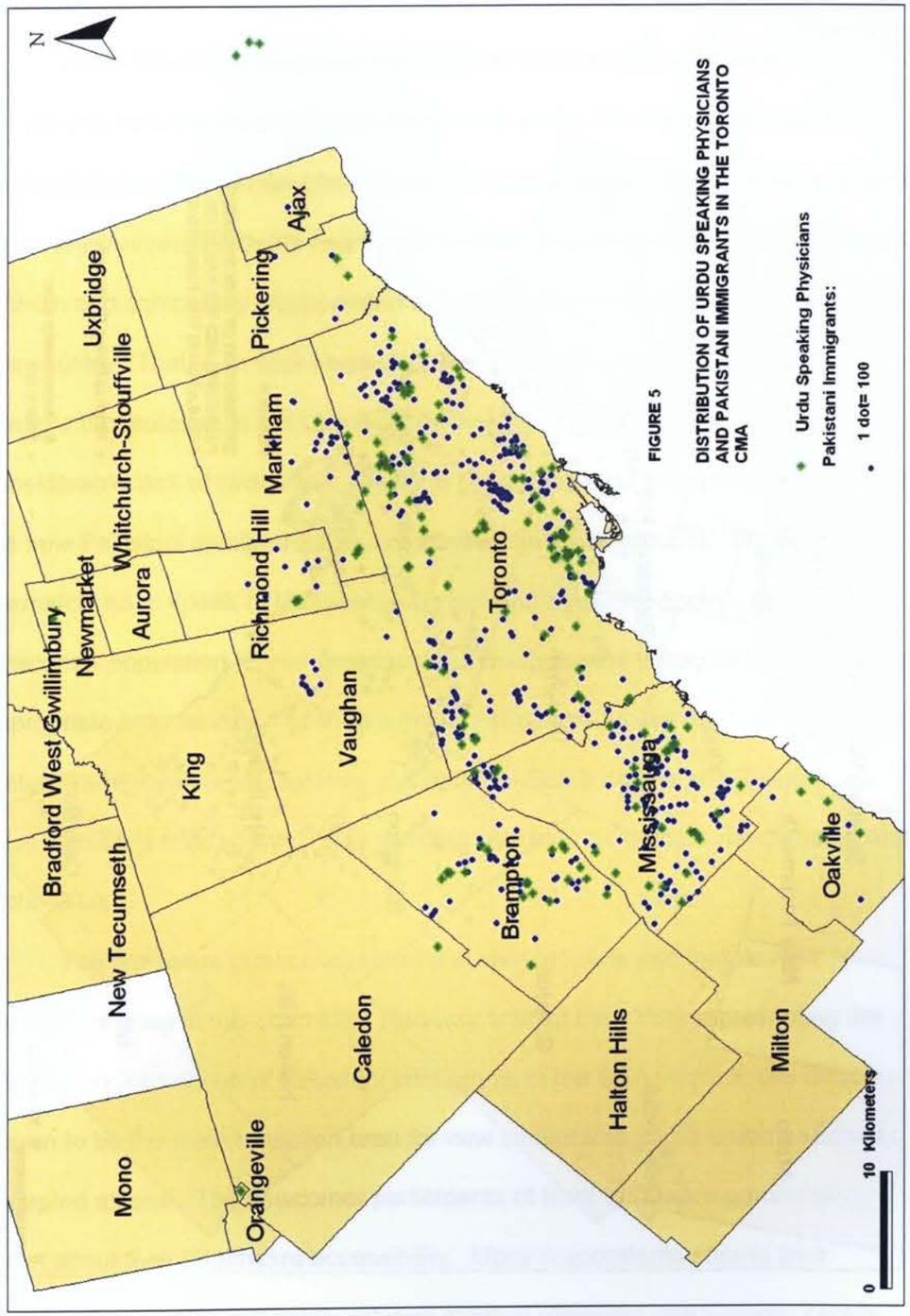


FIGURE 5

DISTRIBUTION OF URDU SPEAKING PHYSICIANS AND PAKISTANI IMMIGRANTS IN THE TORONTO CMA

Urdu Speaking Physicians

Pakistani Immigrants:

1 dot= 100

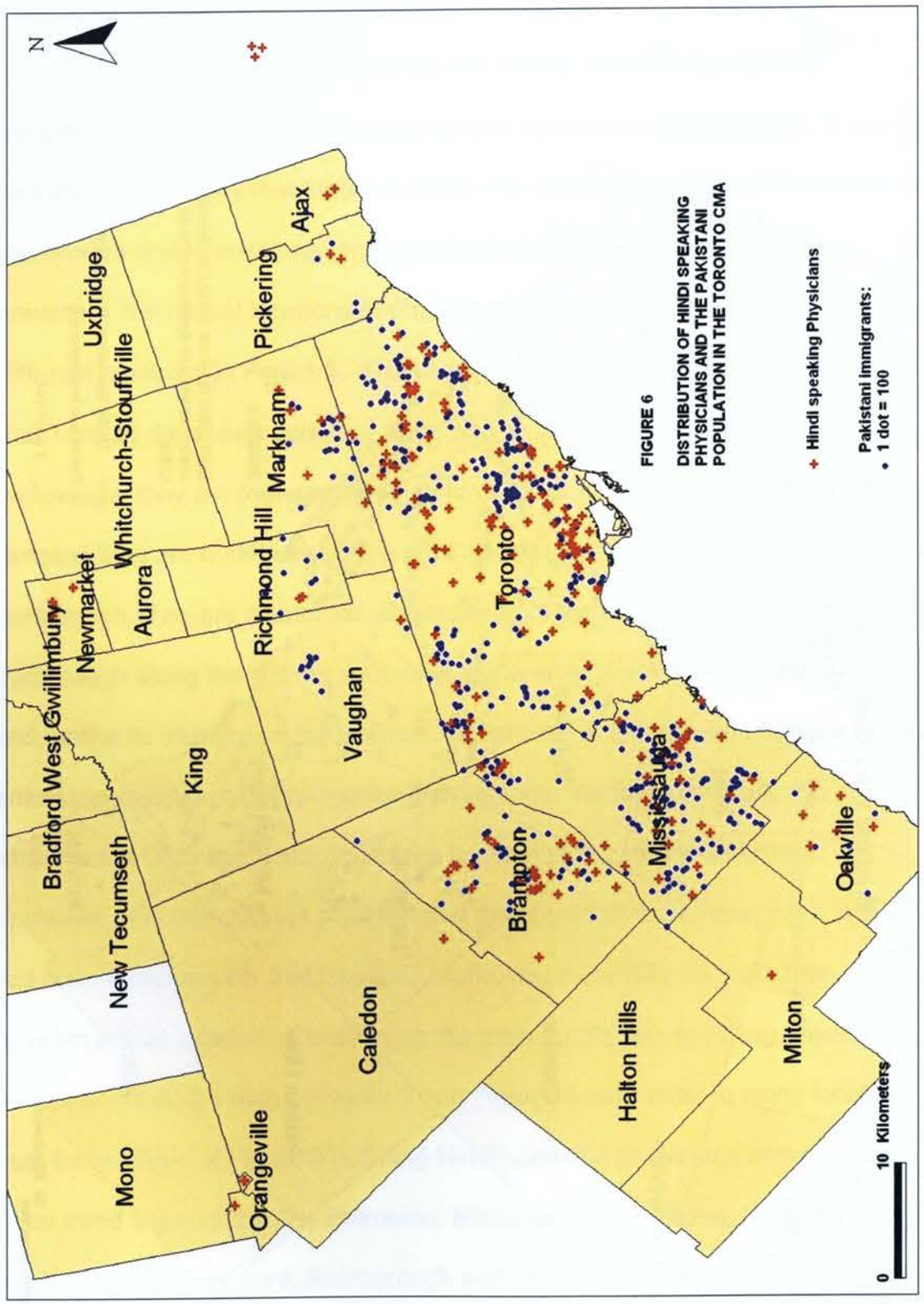


FIGURE 6
DISTRIBUTION OF HINDI SPEAKING PHYSICIANS AND THE PAKISTANI POPULATION IN THE TORONTO CMA

+ Hindi speaking Physicians

Pakistani immigrants:
• 1 dot = 100

physicians.

In the first two focus group that targeted groups of new Pakistani immigrants from the East York and North York areas, the discussions were concentrated on this similar phenomenon of unmet needs. The newcomers were genuinely frustrated with the healthcare system, unaware of the options available to them and completely disappointed with their treatment as new immigrants to this country. That is, in both respective areas, the overlap of the Pakistani immigrant population to the Urdu/Hindi speaking physicians show there is a considerable lack of Urdu/Hindi speaking physicians who are ideally preferred by the new Pakistani immigrants (as indicated in the focus groups). This 'spatial mismatch' so to speak of Urdu-speaking or Hindi-speaking doctors to the newcomer population has imposed great difficulty for the immigrants in accessing appropriate help for their healthcare needs. However, unlike the newcomers, the mature immigrants representative of Markham, Scarborough and Mississauga were incredibly relaxed, and quite satisfied with their healthcare needs being met in the GTA.

The first focus group comprised a mixture of male and female new immigrants living in the Thorncliffe Parkway area of East York representing the largest conglomeration of Pakistani immigrants in the GTA. In fact, this area is known to be the main reception area for new immigrants and it is conventionally accepted as one. The newcomer participants of East York were particularly upset about their healthcare accessibility. Many respondents shared their experiences of being out rightly refused medical attention; one woman, Zahida,

explained how she was "requested to pay $200 for the release of her medical files". Apparently the only reliable physician in the area (according to Nawal, the settlement worker at the Thorncliffe Neighborhood Office) has not been accepting patients for the last 3 years. This has put the residents of the Thorncliffe area at a tremendous disadvantage. The maps indicate that no physicians speaking Urdu or Hindi practice in this area where the need of Pakistani physicians is most evidently the greatest.

A limited number of the newcomer population can easily express their healthcare needs in English. Both of the focus groups including newcomers indicated having a very difficult time securing a stable family physician who could understand their needs. One participant, a 60 year old man named Rahim said spoke of his family physician saying he "does not understand my health problems and the medicines prescribed to me are not effective". However, reconciling with the situation this aged man agreed that "the problem exists due to the language barrier because my doctor is Chinese-speaking" who can converse in Cantonese. It seems as though the language barrier serves to complicate diagnosis where a lack of understanding can lead to misrepresentation of symptoms (Hussain & Cochrane, 2002). The Pakistani female newcomers in the second focus group also shared a significant linguistic barrier. Their ability to express their symptoms or the nature of their healthcare problems was challenging. As such, two women even stated they were subject to their husband's availability so he could chaperone them to the doctor's office and act as an interpreter. In this way, the presence of another family member who had a

better grasp of the language facilitated the women's ability to understand and express their health concerns (Meadows et al, 2001, 1456).

Other participants candidly shared their problems relating to their access to healthcare. Their challenges varied from having no availability of doctors as many doctors do not accept new patients and consequently, the newcomers have no choice but to resort to walk-in clinics which accompany ridiculously long waiting times before they are seen by their doctor (several participants indicate they have waited up to five hours to see a doctor). Even, one third of the mature Pakistanis highlighted their frustrations with waiting times. Saleem, who has lived in Canada for 38 years, stated how his South Asian doctor "take[s] too much time at least three hours for us to see [him]... the thing is that we are stuck there". He further explained that due to the shortage of doctors in the Mississauga area, him and his wife find it difficult to find another doctor. Another participant of the same group, Naeem explained that he "preferred if the doctors abided by their appointment timings" and simply rationalized that "I do not have the time to wait". Later in the same discussion Naeem considered what the situation for new immigrants might be like in accessing healthcare:

> "I am not happy with the shortage [of doctors]..this must be a problem for new immigrants too.. there are options available,.but new immigrants won't be aware of other options like the older immigrants are ..."

It seems as though this is an accurate account of the current situation with new immigrants. None of the participants of the newcomer population were aware of alternative options; they commonly felt cheated upon and dealt with unfairly. Mehna, a new female Pakistani who has been in Canada for less than 6 months

asserted "they say its a country of immigrants but the medical services are not meant for immigrants, they do not understand us". However, it may not be an issue of understanding but precisely the level of awareness or knowledge of other services immigrants are provided with. Mehna (who is pregnant) was not informed of her entitlement to an Obstetrician to take care of her until the arrival of her baby. Certainly seeing a specialist may shorten her weekly four to five hour wait to see her doctor.

The new Pakistani immigrant women raised serious concerns to the accessibility and the cost insufficiency of public transportation, which will be discussed in the next section. Along with their experiences as new immigrants, the seemingly unwanted predicaments of having to long waiting times, the unpredictability of when their appointment will actually take place, and the frustration of not being understood by their physician are major obstacles new Pakistani immigrants confront. The newcomer population is more disadvantaged than the general population due to their limited time in Canada, they are unaware of the system and do not possess adequate resources to locate a physician who they can communicate with and who is accepting patients. In fact, there was a general consensus between both focus groups of new Pakistani immigrants who asserted (with the exception of one female discussant) having extreme dissatisfaction in locating a family physician that fulfills their healthcare needs and the main reason was cited as being a linguistic barrier. Thus, the problem of progression from diagnosis to effective treatment within health services is centred on communication problems (Hussain & Cochrane, 2002). In addition to

this, the problems new immigrants (and the two mature immigrants) face are invariably linked to the physician shortage in Ontario especially of ethnic physicians who have the linguistic skills sets to communicate with Toronto's multiethnic society. This issue is challenging to amend for two basic reasons: licensing bodies have made it extremely difficult for international medical graduates (IMGs) to obtain a license to practice in Canada; and secondly, many trained medical graduates who do obtain their license to practice in Canada end up emigrating elsewhere (Kermode-Scott, 2002).

4.4 Physician shortage

It comes to little surprise that the majority of recent Pakistani immigrants experienced and continue to experience challenges in obtaining quality healthcare. Notably, the mature immigrants did not face the same nature of challenges as the majority of them already had long established relationships with their primary healthcare provider. Many communities in Canada suffer from a shortage of physicians because the distribution of family physicians is inadequate and inequitable (Audas et al, 2005), (Shortt et al, 2005). For instance, in 2000 there was an average of 94 family physicians per 100, 000 Canadian residents. Other communities (such as urban areas) had 140 family physicians per 100, 000, where other rural areas had less than half that number. Many doctors who choose to work in rural areas do not remain beyond the minimum period of their contractual obligation (Audas et al, 2005, 1315).

Much attention has been allotted to care delivery methods and offered solutions from associations and governments to address the physician shortage

in Canada (Audas et al, 2005). However, there is still a substantial and unmet need for health services in many regions of the country (Busing, 2007). One problem is that we are losing too many physicians to the United States. Although this exodus has abated somewhat, further insight of the reasons that fuel this ongoing loss need to be addressed. Different ways to encourage these physicians to practice in Canada need to surface. Even if the repatriation of these physicians will make a small impact, it will be an important contribution to Canada's physician resources (Busing, 2007, 105). Possibilities to maintain physicians to practice in Canada will be explored in the policy implications section.

4.5 Pakistani Women and Health

While research has indicated that female migrants are largely affected by the migratory experience in terms of the their health status (Cooper, 2002), (Dyck, 2004), (Hussain & Cochrane, 2002), (Meadows et al, 2001), (Nazroo, 1997), (Thurston & Vissandjee, 2005), it was not expected that the Pakistani group of women would have the worst experiences in accessing healthcare facilities among the three focus groups. The group of newcomer Pakistani women was extremely disadvantaged in terms of their accessibility to transportation that was inextricably linked to their accessibility to healthcare. Their relatively new status as immigrants did not afford them the opportunity to be well acquainted with their surroundings and found themselves initially to be dependent on their spouse. This was compounded with their inability to speak in

English coherently and their changing yet challenging family/household responsibilities.

The discussion with these women highlighted one paramount factor of their settlement experience as being isolated without their family. The majority of these women have left Pakistan for the first time in their lives and experiencing such exposure that is relatively uncommon in Pakistan. A huge problem is that these women are without the social support of their family they have grown up in and relied upon. Social support refers to the quality of social resources an individual can reliably obtain from his or her network of family and friends (Kaniasty & Norris, 2000). Ethnic differences in social support may exist (Simich et al, 2004) because some cultures like Pakistan are collectivist societies and emphasize communal or family orientations while others are more atomistic like in Canada. Therefore, the quality of social support may vary too since ethnic groups respond differently to stressful events (Simich et al, 2004).

The Pakistani women commented on the stressful event of receiving inadequate medical attention from a physician which varied from: locating a doctor, arranging for transportation to get to the doctor, waiting for their turn to see the doctor and the quality of care received. All of the participants were frustrated by the waiting time one has to incur before being seen by a doctor. In their initial task of locating a suitable doctor in their area, all of the participants (with the exception of one) located a doctor upon the recommendation of a family/friend irrespective of the doctor's location. Having limited access to a vehicle, all of the women expressed dire frustration with the public transportation

facility (eg. The Toronto Transit Commission) available to them. The majority of these women being mothers of young children do not have the option to leave their children with a babysitter or even a daycare. Thus, the children must attend the medical appointments with their mother. One women Sadia explained how "I do not send my son to school the days I have a doctor appointment, the school is unwilling to be responsible for him if I am late to pick him up". Thus, the unpredictability of when her appointment will actually take place and the impracticality of paying for transport to come back and forth from school and/or home means women along with their children wait lengthy hours to receive medical attention they are relatively dissatisfied with. All of the participants were frustrated by the waiting time one has to incur before being seen by a doctor. Rubina indicated that "the waiting times are the worst, I get more sick from waiting for 3-4 hours and by the time I get my turn, my blood pressure is shooted up" while Mehna mentioned:

> "Waiting times are too long, it takes up most of my day ... I have to wait 4-5 hours for the doctor its hard to go for me... I haven't even been here for 6 months, I don't know bus routes so it is very difficult for me to go".

Indeed, some women are doubly challenged in this sense, they have difficulty traveling the distance to access their healthcare provider and must compromise their daily household responsibilities in order to fulfill the waiting time required to see a physician. In this way, the perceived gender role of Pakistani women within the household often limits some women's ability to allocate resources to health maintenance and promotion (Thurston & Vissandjee, 2005, 236). After all, an immigrant should rightly expect to receive sufficient care from their doctor

after conquering many hurdles to reach their doctor. Nonetheless, the situation did not improve for 70 percent of these women who expressed complete dissatisfaction in the care they receive overall from their physician. A young lady, Fatima described her unhappiness stemming from the ineffectiveness of the medicines she is given by her doctor: "The medicine they give me does not help my problem ... they don't know what the problem is and the problem is persisting". Fatima also added that her inability to speak English to her specialist is a significant barrier from getting the treatment she requires:

> "No one is helping me and there is no cure to my joint problem, it is getting worse. I am very upset because of this. [I do have a specialist]... he speaks English, I cannot explain to him my problem and there is no one who can go with me".

Yet, it is completely shocking when these women were asked about their preferences for a Pakistani or Canadian trained doctor, five of the seven participants said they preferred Canadian physicians trained in Canada. This suggests while the participants are considerably distressed about the several obstacles they must confront in order to meet their appointment; they still have sincere faith in the Canadian medical profession and practice. Mehna explained her belief in this by attributing "I have a preference for someone from here 'cause there are rules and regulations and the doctor's pass exams, it is a developed country after all". Similarly, all of the mature immigrants were adamant about having a Canadian doctor trained according to western standards. One female participant, Shabana, commented that a Pakistani doctor she had many years ago "always wanted to gossip with me and my husband would get mad at me so many patients would be waiting". She further concluded that she did not have

time for that and wanted to see a doctor who would get to the point. Perhaps there is acceptance of the problems they incur as newcomers in their initial settlement phase and they visualize their experiences improving as their time in Canada lengthens. Or perhaps like Shabana, these women want to be treated by a medical professional that is serious about their work. These are only speculations as the true cause is unclear. The contrast in having displeasing healthcare experiences but still insisting that they, the new Pakistani women prefer Canadian doctors is a topic beyond the scope of this research requiring further exploration.

An interesting dynamic during the discussion with the Pakistani women revolved around their newly established independent status as women in a westernized society. In Pakistan, a woman is commonly accompanied in public by her male spouse/relative. If they are not, women are commonly stigmatized as too modernized originating from a weak family background. Now that the women are in Canada, they stated that their husbands were more encouraging and wanted their wife to be independent as one participant explained "we were not used to going out there but here we have the freedom and our husbands encourage us to stand on our feet". However, the women find themselves incredibly challenged by these newly found expectations. In their effort to be independent somewhat, they are limited in several ways: by their lack of English speaking skills, having low educational attainment, scant knowledge of the transport system or even attaining a G2 license. In her quest to be independent, Shaista mentioned "my husband wants me to drive but G2 takes so long...We

have to depend on my husband, we have no other choices". Thusly, limitations on what is accessible to them and what is not as newcomers have restricted their effort (for the time being) of achieving independence despite their spouse's support.

4.6 Cultural Difference in Medicine

Literature has taken an extensive account on South Asian women and their experiences in utilizing traditional forms of medicine (Dyck, 2004), (Hilton et al, 2001), however these findings are inconsistent with the female newcomers who participated in this study. In fact, these findings are inconsistent with any findings of this study where participants mainly emphasized their use of Pakistani or Western medicine and preference for each. As for the women, they discussed their trust in Pakistani medicines and found them to be fast relieving as opposed to western medication. Many individuals stated their medicines from Pakistan did not have an impact here (in Canada) as they did in Pakistan reasoning "there is a huge environmental and atmospheric difference" which explains why the "medicines [from Pakistan] don't suit us here". Shaheen another participant commented on how physicians in Canada use different approaches in treatment where "doctors here take steps to treat you and there they take any approach that is quickly beneficial for the patient". Saira noted too that

> "[medicines] from here build up and take impact slowly. We want medicine that is fastly effective especially house wives who have a load of work to do in the home need to have fast pain relief".

It is interesting to note how the preference for Pakistani medicines was a commonality among all new Pakistani immigrants when mature Pakistani

immigrants were completely inclined towards Canadian medicines and even elaborated that "[in Pakistan] the potency of medicine is not available…I am satisfied way more here than in Pakistan". Perhaps the trust in Pakistani medicine for the Pakistani newcomers is interrelated to the quality of healthcare newcomers perceive they benefit from in their homeland. A new Pakistani immigrant, Seema described how Pakistani doctors treat them differently as patients but "we are used to it…so there is a cultural difference, ...we don't understand what the doctor wants or means when they say we have a problem". This inevitably points to the cultural difference in practice of Canadian physicians. Without a physician who can speak their language, have the cultural sensitivity towards their cultural norms and values or even comprehend how they may understand a potential user's need; many new comers may undoubtedly feel more advantaged in their homeland rather than their new country of permanent residence.

4.7 Ethnic Physicians and Practice in the GTA

The South Asian physicians who participated in this study assert that the culture of a physician is very important for their medical practice as is respecting the cultural norms and the cultural beliefs of the patient. One South Asian physician practicing in the downtown core commented how there should be primary care physicians who "can help them [immigrants] understand resources available" while ensuring "that no one falls through the cracks". The other physician stated that patients have a level of comfort with a physician from a particular ethnic background, even if they are required to have a translator in

English. Thus, in this way, the cultural understanding of the physician "is of great benefit in developing a rapport with patients". Although the physicians listed language barrier as the most significant obstacle to healthcare service, the cultural understanding of a physician may mean that potential users do not necessarily have to go to their own ethnic doctor per say to be understood comfortably but can as well benefit from other physicians of varying cultural backgrounds. It would be of great value and interest to consider the role of second-generation ethnic primary care physicians who often understand cultural norms and values but may not speak in the native language.

4.8 Socio-Economic Determinants of Health

The migration experience does not necessarily predict an increased risk to health. However, if certain contingencies are part of the migration experience, migrants may be at increased risk for developing health problems (Naidoo, 1992, 184), (Noh et al, 1999). These contingencies include the following: decline in personal socio-economic status in the host country, lack of proficiency in host languages, separation from family, unfriendly reception by the host population, isolation from people of similar cultural background, pre-migratory stress and traumatic experience and of adolescent or senior age at the time of migration (Naidoo, 1992).

Research indicates that minorities disproportionately experience health problems because of their disproportionate low socio-economic status and are likely to suffer psycho-physiological distress and depressive moods as a consequence (Cooper, 2002),(Vega et al, 1987, 518). In fact, the most salient

factors of racial and ethnic health variation focus on differences in socio-economic status and social support. Two major pathways connect socio-economic status and health. First, poor income and education may decrease access to and utilization of health care services (Wu et al, 2003, 428). There is growing evidence to suggest that medical interventional is less timely and responsive to the poor. Disparities include discontinuous care by a doctor familiar with their mental histories, limited use of preventative health services and less comprehensive testing for illnesses (Wu et al, 2003), (Williams & Collins, 1995). Second, socio-economic status predicts the level of exposure to psychosocial and environmental health risks. Low socio-economic status may be a chronic and acute stressor because this situation compromises individual ability to obtain basic needs and economic security. As such, low socio-economic status can harm overall well-being due to events arising from "unexpected expenses, inflation and unemployment [which] raise the spectre of poverty" (Wu et al, 2003, 428). In addition, low socio-economic status can trap people in poor living conditions with neighbourhoods having high crime rates, poor housing, and deficient amenities (437). Furthermore the overall impact of low socio-economic status may produce feelings of despair and powerlessness that trigger or even exacerbate depression (Wu et al, 2003), (McLeod & Kessler, 1990).

A comparison of the socio-economic factors between the new Pakistani immigrants and the mature Pakistani immigrants of this study shows why it seems the newcomers (as opposed to the mature immigrants) may develop more health problems requiring healthcare services and simultaneously, face

challenges in fulfilling their healthcare needs. Referring again to Table 2 indicates the participant' profiles and shows the mature Pakistani immigrants to be relatively more educated, having higher rates of homeownership and overall, they expressed satisfaction with the quality of healthcare they receive and had limited problems accessing healthcare services. Looking at Table 4 below

TABLE 4 : PROFILE ANALYSIS OF PARTICIPANTS' MUNICIPALITIES

	MUNICIPALITY					
VARIABLE	East York	North York	Scarborough	Markham	Mississauga	Ontario
Visible Minority Population	35.60%	46.80%	60%	55.50%	40.30%	19.00%
Education:						
% of Population aged 35-64						
with University degree	34.00%	18.50%	24.08%	34.06%	28.80%	22.70%
% of Population aged 35-64						
with less than highschool diploma	20.50%	34.40%	25.16%	17.90%	19.40%	23.20%
Homeownership:						
Rented	52.30%	49.20%	37.70%	12.80%	28.20%	32.00%
Owned	47.70%	50.80%	62.30%	87.20%	71.80%	68.00%
Income level:($)						
Average Earnings	$37,068	36,821	29,852	39,260	37,215	35,185
Median Household Income	$46,963	48,153	51,169	77,163	67,767	61,024
Language Ability	58.90%	44.30%	50.80%	48.40%	54.50%	70.60%

(Source: Statistics Canada, 2001 Census).

highlights some choice variables like education, homeownership, income level, and language ability from the municipalities representing the resident locations of participants from Table 2 (namely North York, East York, Scarborough, Markham and Mississauga).

This information extracted from the 2001 Census shows the findings are similar to the profile of the participants from each respective focus group. The municipalities of the mature Pakistani immigrants from Scarborough, Markham

and Mississauga show individuals living in these areas have increasingly better rates of homeownership (62.3%, 87.2%, and 71.8%, respectively). As well the median household incomes in the same areas are relatively higher than other areas ($51,169; $77,163; and $67,767, respectively). It is interesting that all municipalities have a low average of English proficiency, which falls consistently below the Ontario average of 70 percent. This indicates that apart from issues relating to accessing healthcare, immigrants have earning potentials despite their English language skills.

On the contrary, analysis of the data for new Pakistani immigrants tells a different story. These groups of participants are challenged in speaking English, are generally unemployed (underemployed) and the majority rent their homes (see Table 2). Even though the data specific for women in this study is not available, greater unemployment and economic inactivity among working-age Pakistani women suggests they are likely to be most disadvantaged in terms of income, material resources and work-related benefits (Cooper, 2005, 699). Generally, the frustrating experiences of all newcomers are consistent with literature in this domain in saying that people of lower socio-economic status have more difficulties in accessing healthcare and getting the type of treatment they need (Cooper, 2005). Table 4 indicates that the rates of homeownership in the East York and North York areas (47.7% and 50.8%) are well below the Ontario average (68%) along with the rates found in Scarborough, Markham and Mississauga as discussed previously. The rates of homes rented in these areas are the greatest however, exceeding the 32 percent Ontario average with rates of

52.3 percent and 49.2 percent, respectively. The rates of rent and homeownership in East York and North York are practically half and half. It is not clear the role of education and how it relates to the profile of immigrants in these areas. In a study conducted on ethnic minorities, it is thought that levels of educational qualifications are important in the creation and maintenance in health through shaping cognitive skills and learning that are important to maintaining good health (Cooper, 2005, 696). It was found that for Pakistanis, the odds of poor health were substantially reduced for both sexes once education was added to the model (701).

4.9 Mental Health Issues

There is consensus to believe that mental health and the successful resettlement of immigrants in their host country is at serious threat if they are deemed to experience racial discrimination and stigmatization (Al-Issa, 1997), (Canadian Task Force of Mental Health, 1988). Harmful outcomes in terms of physical and overall health result from unfair treatment based on an individual's race or ethnic background. The devaluation of immigrant's occupational or mental abilities is more stressful "when it is based on ethnic background or racial characteristics" of the immigrants as opposed to their actual labour market performance (Al-Issa, 1997, 9). Thus, in Canada discrimination is largely related to the high levels of psychological distress among immigrants and visible minority groups (Noh & Kasper, 2003, 336). Many of the new Pakistani immigrants were eager to discuss the difficulties they have experienced in maintaining a decent job. Many participants indicated several instances of where they were

discriminated against specifically in their efforts to secure employment. Needless to say, the male newcomers were considerably stressed by not having secured employment after months of looking for work and were quite upset at their inability of having their foreign credentials recognized by licensing bodies. In fact, many participants asked me why the research did not focus on labour market problems immigrants' experience.

Other large-scale studies conducted in the United States have showcased prominent links between racial discrimination and psychological well being of immigrants. Results based on two national surveys and a regional study of Detroit analyzed the effect of discrimination on health outcomes. The surveys indicated the self-reported experience of discrimination during the prior month and found that it was interconnected with "increased levels of chronic health problems, physical disabilities, self-reported physical symptoms and diagnosed depression" (Noh & Kasper, 2003, 336). As well, the study highlighted that self-reported discrimination was associated with reduced levels of life satisfaction, happiness, and psychological distress (336).

Chapter 5: Findings and Conclusions

Although Pakistani immigrants have small spatial concentrations, they are geographically scattered across the GTA. The Pakistani newcomers representing East York and North York were extremely disadvantaged in terms of accessing a primary care physician. Their biggest challenges were highlighted in their communication barrier and access to transportation; the most significant problems to being understood by and reaching a physician. Close map analysis revealed that these areas harbouring large populations of Pakistani immigrants do not have a positive correlation to the Urdu or Hindi-speaking physicians who are most suitable to understand the Pakistanis. Due to the long waiting times, and inadequate quality of healthcare services, new immigrants in general preferred having a Pakistani physician trained in Canada whereas the women immigrants preferred a Canadian doctor despite their hardships.

The newcomer Pakistani women faced the most difficulties among all the participants in the study. They were challenged in multiple ways by the loss of family ties, their lack of English speaking skills and their dependency on their husbands' working schedule. Their time spent in waiting rooms often meant an unproductive day maintaining their household responsibilities and was a tremendous source of stress for the women.

On the other hand the mature Pakistani immigrants were in a better position to access their physicians and expressed overall satisfaction in the quality of care they receive. The majority of these immigrants have lengthy residence in Canada (on average more than 30 years) and are proficient in their

English speaking skills. Looking at the socio-economic variables of the participants profile and the municipality profiles revealed that the areas (Scarborough, Markham and Mississauga) where the mature Pakistanis were residents were more likely to have higher rates of homeownerships and higher household incomes than East York and North York where the new immigrants reside. It is believed that contingencies related to the migration experience including a decline in socio-economic status can disproportionately impact minorities and pose as a serious threat to their overall health (Cooper, 2005).

Chapter 6: Limitations

The research paper cannot be completed without an accurate account of the constraints in conducting this study. In comparison to other qualitative work, this study was small which may limit the transferability of its findings. If time allowed, the organization of more focus groups representative of the all municipalities would have greatly benefited this research as it was extremely difficult to organize and implement three focus groups in a two-week time frame. Therefore, since the focus groups were not completely representative of the GTA population, I have made grand generalizations with the data on hand. Next, there is disappointment that the backup strategies to convince South Asian physicians participation were not as effective as initially hoped. A significant contribution would have been to have face-to-face interviews with South Asian physicians from across the GTA. This could be conducted for future research and would be extremely beneficial for understanding the accessibility to healthcare issue in depth. Third, in considering the data collection tools utilized, I feel that I could have been more flexible in the questions called and chosen a more open-ended, unstructured group interview though this would have probably been more appropriate if I focused on one aspect of healthcare accessibility. Lastly, as researchers, there are data limitations and I have been hostage to what is and is not available; the only access I have is to census tract level data. It would be very interesting to consider census 2006 variables in this analysis had they been released. Overall, I am surprised at the rich content of the discussions that have contributed enormously to this study.

Chapter 7: Final Remarks and Contributions

This research paper will be an integral contribution to knowledge in three specific contexts: theoretical, policy implications and practical application. It is evident that previous literature pertaining to ethnic groups and their accessibility to healthcare is severely limited, especially in a multicultural society such as Toronto. This study has discovered that new Pakistani immigrants experience greater difficulty in accessing a physician in comparison to the mature Pakistani immigrants. They have difficulty locating a physician in their vicinity who is accepting new patients, and who can speak the Urdu language. In turn, the immigrants have no other option but to resort to walk-in clinics where the expected waiting times were anywhere from three to five hours to see their doctor.

Overall, language was specified as the most significant barrier for the new Pakistani immigrants. As for the Pakistani female newcomers, they were extremely frustrated in terms of their lack of communication skills with their doctors and their inability to explain their symptoms and healthcare needs most effectively. These women do not know of any options available to them, they have no access to a vehicle and must rely on public transportation. However, the reliance on public transportation is limited to when their husband's job schedule permits a visit to their doctor as a spouse (or even children) is expected to act as a translator.

The challenges Pakistani women face are important for health promotion and preventative policy and programs that are relevant to the experiences and

lives of the women they target (Meadow et al, 2001). Furthermore, there is a need for greater attention to gender and diversity in all health promotion and in health policy at the local, provincial and federal levels (Thurston & Vissandjee, 2005). A research programme examining the migratory experience in relation to gender and how they intersect in health promotion will do more to assist in overcoming the marginalization of minorities (Thurston & Vissandjee, 2005, 239) with an exclusive focus designated to the improvement of immigrant accessibility to health services.

The more positive aspect of this study is related to the experiences of mature Pakistani immigrants. Being comfortable with their life in Canada, these immigrants agreed that they are familiar with the healthcare system and if they were not satisfied with their healthcare needs, they would find options to improve it. Only one third of the mature immigrants expressed frustration with the waiting times at their physician's office while the majority of immigrants, having long established relationships with their physician, were satisfied with their physician and had minimal problems. The lived experiences of mature immigrants indicate that the problems new immigrants are facing may prove to be short-lived experiences. As new immigrants' length of residence increases in Canada, over time their awareness level rises and they become more conscious of their surroundings and thus, it is expected their standard of living improves. That is, their accessibility to a physician, the acquisition of a vehicle, more confidence in the Canadian healthcare system and greater affordability will over time improve the overall situation of new immigrants

Apart from the preference of having a same-ethnic physician as expressed by the new immigrants, one physician suggested a plausible alternative. This South Asian physician who did not speak a native language of Hindi or Urdu stated to having at least 25% Pakistani patients. She asserted that the culture of a physician is very important as patients have a comfort level with a physician from a particular ethnic background even if they need to have a translator attend the appointment. In this way, cultural understanding on part of the physician is very important in developing a rapport with their patients. Another physician commented that physicians hold a great responsibility as operating as the cultural bridge for the patient to their new host society and should be able to link their patients to the required services (within the community) suited for their particular healthcare needs. However, this situation can prove difficult for immigrants like Shazia, who is suffering from painful joint problems and acknowledges it is due the lack of communication with her doctor as she has no one who can attend her appointments to help in translating. It is unexplainable why the new Pakistani female immigrants still desire to have Canadian doctors when they have a clear communication problem with English speaking doctors.

In fact, policy makers need to assess the potential role of physicians in improving and helping immigrants receive the necessary healthcare information they require to obtain sufficient healthcare services. Through the facilitation of social workers, settlement workers and other community organizations (such as a Muslim Community Centre), all medical offices and/or community organizations should be allowed to provide necessary pamphlets and contact information

related to transportation and other healthcare accessibility concerns.

There is an obvious spatial mismatch in the service provision and uptake in many areas of the Toronto CMA. Clearly in East York and North York, where significant concentrations of Pakistanis reside, there are limited physicians speaking Urdu or Hindi (see Figure 5 and Figure 6). Interestingly, in the other areas such as Scarborough, Markham and Mississauga where the municipalities seem to have a higher socio-economic profile (see Table 4) and happen to be the resident municipalities of the mature Pakistani immigrants, there is an adequate spatial distribution considering the Pakistani population residing there. Furthermore, the under-serviced areas in this study (East York and North York) are those with a low socio-economic profile where new Pakistani immigrants tend to initially locate. As highlighted by the focus groups, East York where Thorncliffe Parkway area is maintained as a main reception area in Toronto, there is a clear need for Pakistani physicians who have cultural understanding of immigrant patients. Along side this need is also understanding the complexity of the physician shortage problem in Canada and what direction policy initiatives must take in order to see a proportionate balance of physicians to residents in any given area.

Literature in the field highlights that the substantial decrease of physicians in medical school is one of major concern. Evidence suggests there was a substantial drop in the number of physicians entering practice from 1994 to 2000 from the rate of entry 1990 to 1993 (Shortt, et al, 2005, 208). While the Canadian government is committed to increasing the domestic production of

family physicians (Shortt et al, 2005), in order to be self-sufficient, it involves admitting more Canadian students to medical school. Currently, there are 2500 medical school positions in Canada but the requirement is for a total of 3000 positions. The reduction of medical school enrolment in the early 1990s impacted the physician workforce as the total applicant pool declined. While physicians continue to leave the country, the situation is expected to worsen (Kermode & Scott, 2002).

The decrease in entering the practice and graduating from medical school can be explained by some leading factors. There seems to be a huge disparity between specialized and family physicians incomes that are attributed largely to decisions made by the Ontario Medical Association (OMA). Family physicians are viewed as disadvantaged compared to specialists. Thus, to encourage recruitment (and ultimately retain the recruitment), primary care as a discipline must be seen adequately compensated. The inability to secure this will mean the loss of potential recruits to other specialties or jurisdictions where financial gains are perceived to be more attractive. The perception of a deteriorated economic position is accompanied by the concern of workloads for family physicians becoming sufficiently unmanageable as to attribute a disincentive to enter the field. A survey conducted by the Canadian Medical Association, it is reported that from 1992-1993 to 1999-2000 reveal the amount of patients seen per day by Ontario family physicians increased by almost five percent, the hours per week increased by ten percent and the number of patients seen per week by over ten percent (Shortt et al, 2005, 211).

Another challenge involves the recruitment of international medical graduates (IMGs) into the health care system; it is one way to relieve the physician shortage (Clarke, 2002, 24). The integration of IMGs into the healthcare system, involves the development of ethnically sound recruiting practices, which require a national funding strategy. This would include a standardized assessment program identifying IMGs who are ready to practice, those who require additional training, and those who would be better suited to other health care professions (Busing, 2007, 1057). The Medical Council of Canada Evaluating Exam was criticized for initiating the frustration with Canada's treatment of IMGs (Clarke, 2002). It was argued that the intent of the exam was to have one take it several times. The main areas of evaluation were psychiatry, public health and epidemiology. Thus, all physicians were evaluated with the same exam without consideration to test the skills of the highly trained specialist but rather to prove a physician's ignorance in concepts useless for his/her practice (Clarke, 2002, 32). An ethnical recruitment process would revoke such practices. Integrating more IMGs into the educational system would mean further burdening the overtaxed system, thus, it needs to be ensured that there would be increased funding for the infrastructure and additional teachers.

The practical contribution of this research is the applied value of the study. Upon my own experience in job searches especially in the federal government, it was discovered that Health Canada has a significant demand for individuals who are well aware and experienced with healthcare issues pertaining to minority populations in Canada. Therefore, I believe the gained experience from this

research will enhance my employment prospects upon completion of the research.

REFERENCES

Al-Issa, I.A. 1997. "Ethnicity, Immigration, and Psychopathology" in *Ethnicity, immigration and psychotherapy*. New York: Plenum Press.

Anderson, M. and Rosenberg, M.W. 1990. "Ontario's under serviced area program revisited: and indirect analysis" in *Social Science and Medicine*, Vol. 30: 35-44.

Awan, Sadiq Alam. 1989. *People of the Indus Valley: Pakistani Canadians*. Canada: the Canada-Pakistan Association.

Balakrishnan, T.R. & Gyimah, S. 2003. "Spatial Residential Patterns of Selected Ethnic Groups: Significance and Policy Implications" in *Canadian Ethnic Studies*, Vol. 35(1): 113-125.

Beiser, M. 1988. "Influence of Time, Ethnicity, and Attachment on Depression in Southeast Asia" in *The American Journal of Psychiatry*. Vol. 145(1).

Beiser, M. et al. 2004. "Unemployment, underemployment and depressive affect among Southeast Asian refugees" in *Psychological Medicine*. Vol. 23: 731-793.

Beiser, M. et al. 2002. *Ethnic Identity, Resettlement Stress and Depressive Affect Among Southeast Asians in Canada*. CERIS Working Paper Series.

Beiser, M. et al. 1993. "Unemployment, underemployment and depressive affect among Southeast Asian refugees" in *Psychological Medicine*. Vol. 23: 731-743.

Beiser, M. and Wickrama, K.A.S. 2004. "Trauma, time and mental health: a study of temporal reintegration and Depressive Disorder among Southeast Asian refugees" in *Psychological Medicine*. Vol. 34: 899-910.

Berry, J.W. et al. 1987. "Comparative Studies of Acculturative Stress" in *International Migration Review*, Vol. 31 (3):491-511.

Buske, L. 1997. "Canada's International Medical Graduates" in *Canadian Medical Association Journal,* Volume 157, 1-2.

Citizenship and Immigration Canada. Facts and Figures. Online http://cic.gc.ca/english/research/menu-fact.html. Accessed April 7, 2007.

Clarke, P. 2002. "The Foreign Question: We Have a Critical Physician Shortage in Canada. There are Hundreds of International Medical Graduates who Aren't Allowed to Practice Here. Is There Something Wrong with This Picture?" in *Medical Post,* 38 1-4.

College of Physicians and Surgeons of Ontario. Advanced Doctor Search. Online http://www.cpso.on.ca/Doctor_Search/adv_srch.asp?SCR=FIRST. Accessed February 25, 2007.

Cooper, H. 2002. "Investigating socio-economic explanations for gender and ethnic inequalities in health" in *Social Science and Medicine*. Vol. 54: 693-706.

Dyck, I. 2004. *Immigration, Place and Health: South Asian Women's Accounts of Health, Illness and Everyday life.* Research funded paper by RIIM, The Vancouver Centre of Excellence in Research on Immigration and Integration in the Metropolis.

Dyck, I., Kearns, P. 1995. "Transforming the relations of research: towards culturally safe geographies of health and healing" in *Health & Place.* Vol. 1, pp.137-147.

Flowerdew, Robin & Martin, David. 2005. *Methods in Human Geography: A guide for students doing a research project (2nd edition).* Essex, England: Prentice Hall.

Fricker, Ronald D. & Schonlau, Matthias. 2002. *"Advantages and Disadvantages in Internet Research Surveys: Evidence from the Literature*" in Field Methods. Vol. 14(4): 347-367.

Hyman, I. 2004. "Setting the Stage: Reviewing Current Knowledge on the Health of Canadian immigrants" in *Canadian Journal of Public Health.* Vol. 95 (3).

Kermode-Scott, B. 2002. "Are We Relying too Much on IMGs?: Canada Should Try to be 'Self-Sufficient'(International Medical Graduates)" in *Medical Post, 38* 1-6.

Laditka, J.M. 2004. "Physician supply, physician diversity, and outcomes of primary health care for older persons in the United States" in *Health & Place.* Vol 10: 231-244.

Laroche, Mireille. 2000. "Health Status and Health Services Utilization of Canada's Immigrant and Non-Immigrant Populations" in *Canadian Public Policy,* Vol.26 (1): 51-75.

Leduc, N. & Proulx, M. 2004. "Patterns of health services utilization by recent immigrants" in *Journal of Immigrant Health.* Vol. 6:15-27.

Magocsi, 1999. *Encyclopedia of Canada's Peoples.*

McIsaac, E. 2003. *Immigrants in Canadian Cities: Census 2001 – What do the data tell us?.* Maytree Foundation.

McLeod, J.D. & Kessler, R.C. 1990. "Socioecoomic Differences in Vulnerability to Undesirable Life Events" in *Journal and Health and Social Behaviour*, Vol. 31: 162-172.

Meadows, L.M., Thurston, W.E., Melton, C. 2001. "Immigrant women's health" in *Social Science & Medicine.* Vol. 52:1451-1458.

Morgan, David L. 1996. "Focus Groups" in *Annual Review of Sociology*. Vol. 22:129-52.

Naidoo, Joesphine C. 1992. "The Mental Health in Visible Ethnic Minorities in Canada" in *Psychology & Developing Societies* Vol.4 (165): 165-186.

Nazroo, J.Y. 1997. *Ethnicity and Mental Health.* Policy Studies Institute. Report No. 842.

Newbold, K.B.; Eyles, J.; Birch, S.; Wilson, K. 2007. *Building a Profile of Health Related Services: Hamilton's Immigrant and Refugee Communities.* McMaster University Working Paper Series #19.

Noh, S. and Kaspar, Violet. 2003. "Diversity and Immigrant Health" in *The World in a City*. Toronto: University of Toronto Press.

Omidvar. R. and T.Richmond. 2003. *Immigrant Settlement and Social Inclusion in Canada.* Working Paper Series Perspectives on Social Inclusion. Toronto: the Laidlaw Foundation.

Thurston, W.E. & Vissandjee, B. 2005. "An ecological model for understanding culture as a determinant of women's health" in *Critical Public Health.* Vol. 15(3): 229-242.

Shortt, S.E.D., Green, M.E., & Keresztes, C. 2005. "Family Physicians for Ontario: An Approach to Production and Retention Policy" in *Canadian Public Policy, xxxi* 207-221

Simich, L. et al. 2005. "Providing Social Support for Immigrants and Refugees in Canada: Challenges and Directions" in *Journal of Immigrant Health.* Vol. 7(4).

Simich, L. et al. 2004. *Meanings of Social Support, Coping, and Help-Seeking Strategies Among Immigrants and Refugees in Toronto.* CERIS Working Paper Series.

Statistics Canada. 2007. 2001 Community Profiles. Online http://www12.statcan.ca/english/profil01/CP01/Index.cfm. Accessed Aug. 20, 2007.

Steele, L. et al. 2002. "The Impact of Policy Changes in the Health of Recent Immigrants and Refugees in the Inner City" in *Canadian Journal of Public Health*. Vol. 93 (2).

Thurston, W.E. & Vissandjee, B. 2005. *"An ecological model for understanding culture as a determinant of women's health*" in Critical Public Health, Vol. 15 (3): 239-242.

Vega, W.A. & Rumbaut, R.G. 1991. "Ethnic Minorities and Mental Health" in *Annual Review of Sociology*, Vol. 17: 351-383.

Vega, W.A. et al. 1987. "Migration & Mental Health: An empirical test of depression risk factors among Mexican American women" in *International Migration Review*, Vol. 21: 512-30

Wang, L. 2007. "Immigration, Ethnicity, and Accessibility to Culturally Diverse Family Physicians" in *Health and Place* 13: 656-671.

Ward, V.M.; Bertrand, J.T.;& Brown, L.F. 1991. "The comparability of focus group and survey results" in *Evaluation Review.* Vol 15: 266-83.

Williams, D.R. & Collins, C.A. 1995. "U.S. Socioeconomic and Racial Differences in Health" in *Annual Review of Sociology*, Vol. 21: 349-86.

Wright, K.B. 2005. "Researching Internet-based Populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services" in *Journal of Computer-Mediated Communication.* Vol. 10(3): article 11.

Wu, Z. et al. 2003. "Race, Ethnicity, and Depression in Canadian Society" in *Journal of Health and Social Behaviour*, Vol. 44(3): 426-441.

Zhang, J. and Verhoef, M.J. 2002. "Illness management strategies among Chinese immigrants living with arthritis" in *Social Science and Medicine.* Vol. 55 (10):1795-1802.

APPENDIX A

QUESTIONS for FOCUS GROUPS

Acquiring a Family Physician:

1) How did you find your family physician doctor? What was the most significant factor in choosing your doctor of choice? Eg. language, distance, same ethnicity
2) How often do you visit your family physician? Are you satisfied with the quality of care you receive from your physician? Explain.

Experience with Family Physicians:

3) Are you satisfied with the quality of care you receive from your family physician? Explain. A) What main factors would improve your experience with your healthcare physician? B) What main factors contribute to your satisfaction with healthcare you receive?

4) If you do not already, would you consider going to a Pakistani family physician? Why/ why not? a) do you have a preference for physicians trained in Canada or those trained in South Asia? b) how about those from India vs. Pakistan?

5) In your view, what is the cultural difference between Western medicine and traditional Pakistani/South Asian medicine? (eg. different views towards health and managing illness, traditional medicinal approach)

6) Do you bring medicines from your country of origin? If yes, what do you bring? Do you prescribe medicine for yourself (instead of going to a doctor) in Canada?

Accessibility Issues

7) Overall are you satisfied with your ability to access family physicians? What barriers do you think exist for immigrants?

8) Generally, what advantages do you think there are in having a same ethnic physician? Do you think barriers exist preventing Pakistani immigrant accessing same ethnic family physicians?

APPENDIX B

Physician short questionnaire survey

Snow-ball sampling method

Physician characteristics:

1. Pakistani or Indian origin?
2. Language spoken? (Urdu, Hindi, Punjabi)
3. First (second) generation immigrant physician vs. second-generation?
4. Area of practice in the GTA?

Introduction

Canada is an immigrant country and Toronto is one of the most multicultural cities in the world. Almost half of Toronto's population were born outside Canada. The physicians in Toronto are also a diverse group, coming from different cultural backgrounds and speaking various languages other than English and French. Given the multicultural context, we are interested in exploring the health care-seeking behaviour of various immigrant groups, with the hope to understand how immigrants integrate in the domain of health. We conducted a few surveys with South Asian and Chinese immigrant communities in Toronto from a patient perspective on the utilization of health care services. In this questionnaire, we would like to ask you a few questions with regard to immigrant access and utilization of physician services. Your views and answers would greatly help us understand the dynamic between the demand and supply of physician care in the context of diversity, as well as patterns of health care utilization and barriers to access. We thank you for your time.

We would like to have some understanding of the ethnic mix of your patients.

1. Do you have patients who are **immigrants** from other countries?

   (1) Yes (2) No (End the questionnaire)

2. In your observation, do you have patients from the following ethnic groups?

   (1) Pakistani (2) Indian (3) Sri Lankan (4) Chinese (5) Bangladesh (6) Other. Please specify_____ (Need your input on possible ethnic groups/countries of origin)

3. What is the approximate percentage of **Pakistani immigrants** among your patients?

   _____% (Use zero if you do not have any.)

What language do you use most often to communicate with Pakistani immigrant patients?

(1) Urdu (2) English (3)Punjabi (4) other possible language? (5) Other. Please specify_____ (6) Not Applicable

4. What is the approximate percentage of **Urdu-speaking** patients among your patients? _____%

   What language do you use most often to communicate with **them**?

   (2) Urdu (2) English (3) Other. Please specify_____ (4) Not Applicable

5. What is the approximate percentage of **Punjabi-speaking** patients among your patients? _____%

   What language do you use most often to communicate with **them**?

   (1) Punjabi (2) English (3) Other. Please specify_____ (4) Not Applicable

6. Add other language groups? (Sinahla??)

7. Do you have patients of non-South Asian background?

   (1) Yes (2) No

   If yes, what ethnicities are they?

   (1) Caucasian (2) Chinese (3) Iranian (4) Pilipino (5) Other. Please specify_____

8. In your view do you think immigrants **under utilize** health care services compared to non-immigrants?

   (1) Yes (2) No

9. What in your view are the major **barriers** to quality health care for first-generation immigrants?

   (1) language (2) knowledge of the host society (3) location in the city

   (4) transportation (e.g. access to a car) (5) others. Please specify _____

Open-ended question:

1. In your view, what measure can possibly improve immigrants' access to health care in order to achieve equal access to care among different social groups?

2. In your view, is culture important in delivering care and in what way is it important?